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ABSTRACT

The technique of intervention in which the mother directly treats her child is illustrated by a case study of a five-year-old child. In the study, descriptions are provided of the therapist's sessions with the mother, the mother's work with her daughter, and the impact on the child's functioning as the treatment unfolds. Some of the potential hazards and limitations of this technique are also discussed. (DB)

BETSY: THE TREATMENT OF A PRE-SCHOOLER VIA THE MOTHER

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While there has been a great deal of discussion in the literature of helping the young mother [illegible] the development of her pre-school child (via support, education, exploration of their feelings as a parent), there has been little written about helping the sensitive parent directly treat her own child. A growing number of authors have explored this technique of intervention (Anthony, [illegible], [illegible], Fraiberg), and several training centers (child therapy training programs in Cleveland, Ohio and Hampstead, London [A. Freud]) have incorporated this method of intervention as an integral part of their training. Because of the unique relationship of the mother and young child, because of their unusual mutual unconscious closeness, the mother can understand and influence her child to an extent never possible again. The case of Betsy is a clinical illustration of this guided treatment process which lasted for a period of 1½ years.

Betsy, a five year old child in the process of consolidating a severe neurosis, was profoundly depressed, inhibited, fearful and, at times, seemed disoriented. Severe emotional preoccupations markedly interfered with her intellectual development and there was general concern that Betsy was retarded. Through the treatment process between mother and child, several major conflicts emerged and were effectively dealt with: Betsy's intense rivalry with her younger brother; her traumatic reaction to the mother's earlier extended hospitalization; and an enormous preoccupation with sexual differences. In addition, in the

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[illegible] in treatment during [illegible], and [illegible] were able to closely observe and record her changes in functioning through numerous school observations. In the course of this paper, I will describe the therapist's relations with mother, the mother's work with her daughter, and the impact on [illegible]'s functioning as the treatment unfolds. I will also discuss and evaluate some of the potential hazards and limitations of this technique as they became evident in the course of treatment.

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BETSY: THE TREATMENT OF A PRE-SCHOOLER VIA THE MOTHER

INTRODUCTION:

The term "mother guidance" has been commonly used in the child psychiatric and social work literature, and it describes a variety of techniques which seek to educate and support the mother in the early phases of parenthood. More specifically, it is usually described as an educational process with parents which enables them to further all aspects of their child's ego development - to help them cope with the unfolding drive development in their child, to foster sublimations, to handle difficult reality situations, etc. Effective mother guidance is seen as a preventive against later emotional disturbance, and it particularly utilizes the close unconscious communication that exists between mother and her young offspring.

A much less common term is "treatment via the mother", a major therapeutic intervention which has been articulated primarily by the child analytic group in Cleveland (R. Furman and Katan, 1969, E. Furman, 1957). While this process incorporates many of the purposes of "mother guidance", it goes a great deal further in making use of this unique bond between mother and child. It attempts to help parents directly do therapeutic work with their young child when the child has already developed internalized conflicts, and it also attempts to help parents understand some of the unconscious meaning their child has for them internally. Unfortunately, the techniques of "treatment via the mother" have only had limited discussion and usage, and this is particularly

unfortunate because it has enormous potential advantages. Fundamentally, it has the potential of avoiding the costly process of direct psychotherapy for the child, and the sense of "losing" the child to the therapist that treatment so often evokes in parents. "Treatment via the mother", since it is done primarily by the mother, also can maintain the mother's sense of activity and parenthood in undoing some of the psychic damage her child has suffered.

The major purpose of this paper is to provide a clinical illustration of this form of guided treatment through Betsy and her mother, in a process which lasted about one year. I will describe my sessions with mother, the mother's work with her daughter, and the impact on Betsy's functioning as the treatment unfolded.

THE PATIENT: SYMPTOMS AND HISTORY

Betsy was 5½ at the time of referral. She was a tall, pleasant looking child, with large, heavily ringed eyes, who generally, however, gave a "not-all-put-together" impression. There was an awkwardness about her that was immediately striking. She seemed somewhat untidy and disheveled, and she had a lost, faraway and preoccupied look. Her eyes looked inward rather than outward, and her gait was stiff and restricted and without any grace.

She came from a middle class protestant family. Her father, Mr. N., was an executive accountant for a large firm, and Betsy was the middle child in a sibship of 5. Chris, her oldest brother was 12. The other children clustered together in age - Leslie, her older sister was 7 years old, David was 4 at the time of referral, and finally, Donald, her youngest brother was just a few months old when we first met the family.

As we gathered material in our evaluation, it seemed clear that Betsy was in a great deal of emotional trouble. She seemed profoundly depressed, inhibited, and at times disoriented. Her preoccupation seemed to interfere markedly with her cognitive development, and the parents had been concerned for several years that Betsy might be retarded. She never seemed able to remain involved in any sustained play. She tended to drift from any house or doll play with peers to less structured role defined play (e.g., climbing) with children younger than herself. Intense frustration emerged with anything that required some concentration (when learning to dress herself, etc.). At 5 years of age, Betsy was unable to use crayons, cut with scissors, or make any kind of distinguishable representational forms in her drawings. All of her drawings deteriorated into a mess, one color on top of another.

Another area of concern involved behavior problems at home. Betsy was extremely messy, spilled many things, and the parents felt, despite her awkwardness, that there was an intentional quality about her activity. For example, shortly after the family had acquired new carpeting, Betsy tore papers on the floor, put baby powder all over the rug, and managed to break some eggs on the new purchase. There was, in addition to this indirect form of aggression, open continuous rage expressed toward her brother David. At times she hurt him rather severely by biting him, or attacking his head with her fists. In contrast to the evident behavior difficulties at home, Betsy was characteristically shy and enormously fearful outside. She resisted playing outdoors, was frightened of new situations, and afraid at times to enter the church, library, or the neighborhood supermarket.

For several years there had also been periods of intermittent bed wetting, nightmares, and sudden tendencies for Betsy to wander off and to be found several blocks from home.

A major factor in Betsy's history was the mother's marked depression. The mother became enormously sad after the birth of David, when Betsy was just over one year of age. She was dominated by the thought that David would be her last child, and the fact that this might end her child bearing years was an intolerable one for her. Her depression became increasingly acute, and she was aware she felt more and more estranged from her family. When Betsy was three, Mrs. N. began psychotherapy and after ½ year of treatment, it was necessary for her to be hospitalized for several months.

In describing Betsy, Mrs. N. felt that the other children seemed to handle the family turmoil much better. Betsy was always the sensitive one. She cried more easily as an infant, fought toilet training at the age of two, unlike the others, and regressed markedly during her mother's hospitalization (constant bed wetting, crying and intense sleep troubles).

Psychological testing (projectives and intelligence tests) indicated that Betsy had at least average I.Q. potential, and there was surprising strength and form in her fantasy production. We were left with many diagnostic questions. Was Betsy a child who was showing a great deal of narcissistic damage because of a mother who libidinally withdrew during Betsy's early developmental years? What was involved in her

profound lack of general skill development? Were we dealing with a child who had a fundamental impairment in her ability to neutralize energy, or was there much secondary interference with ego functioning due to excessive use of primitive defenses? Our recommendations were twofold: 1) to have Betsy enter the therapeutic nursery school which was part of our clinic and, 2) for a therapist to begin work with the mother for further clarification. Our intent was to periodically reassess the situation to determine whether direct treatment for Betsy would be necessary in the future, and to try to understand how much of Betsy's problems were immediately reactive to family pathology.

INITIAL PHASE OF TREATMENT: SEPARATION THEMES AND PROBLEMS OF AGGRESSION

My first meeting with Mrs. N. was during the summer prior to the start of nursery school so that we could have ample time to prepare Betsy for the new experience. Mrs. N. was a slight, brown-eyed, attractive woman in her mid-thirties. In those early summer meetings, Mrs. N.'s anxiety was striking. She appeared very frightened and there was much hand wringing and eye blinking. She seemed very remote, allowed little eye contact and she spoke almost inaudibly in short sentences and phrases, breathing deeply. I found myself being very gentle and reassuring with her and noted in a number of ways that it was often hard for mothers to come to discuss their children or openly bring problems their child had. But Mrs. N.'s overt anxiety was maintained for quite a period of time.

There was a passive, resigned, fatalistic acceptance of the nursery school plan. This arrangement was recommended by many for Betsy (by her own therapist, her pediatrician, by me) so it must be a good idea.

When she spoke about Betsy, her problems and troubles faded into the oast. Her emphasis was on how well Betsy was doing this summer. She had more friends, she was easily going off to Bible school with Leslie, her s ster, and she was well liked by her teachers. I felt that the intent of her minimization of difficulties was a plea to me to conceive her as an acceptable mother. I would mention from time to time that parents sometimes worried when they began that they would be criticized, found wanting, and blamed for their child's problems.

There was also a helpless, fragile quality about Mrs. N. during those early contacts. She slowly brought in the problem of Betsy's attacks on David. As we discussed this, mother was an overwhelmed witness and bystander to severe assaults and she would allow Betsy to express her full aggression. As we spoke, Mrs. N. began to talk about intervening forcefully and physically stopping the battles (which I strongly and firmly supported) but it was evident at this point mother could actually do very little. Similarly in our attempts to help mother anticipate with Betsy what nursery school would be like, mother could evoke little energy.

It became clearer that Mrs. N. was preoccupied with herself, and she responded quickly to my comments about her self-absorption. After recently giving birth, she was very concerned about a reoccurrence of another acute depression. Yes, she was watching herself carefully for the early warning signs, and for the present, acknowledged it was hard for her to attend to Betsy and her problems.

When Betsy finally started nursery school in the fall, we noted extensive separation problems. Betsy was totally frozen and inert, and mother seemed at least as lost and frightened at the school.

In her sessions, Mrs. N. denied Betsy's fears. Betsy "loved" her new school, though any specific discussion she quoted of Betsy involved fears of the other children and concerns about injury. Mrs. N. also "loved" Betsy's teacher, Sandy, and proclaimed how wonderful and helpful she was. The underlying feeling, however, was that Sandy was a much more adequate, thoughtful, maternal figure than she. In this period she reported an upsetting incident which happened at home. The children were discussing a neighbor who was raising three children who were not her own since the natural mother was chronically ill. In the midst of the discussion, Betsy suddenly turned to her mother and asked "Are you going away again, Mommie"? As she described this to me, Mrs. N. looked evidently distressed. I commented that this seemed like a rather natural question that one would expect from Betsy as she started school, but I could see this was very upsetting to Mrs. N. Mrs. N., for the first time, brought forth some real affect as she described how guilty she felt about Betsy. For a long period of time during her depression she only went through the motions of being a mother to both Betsy and David. She walked like a robot, was in an eternal daze, and was unable to think about her children. She wasn't sure that she always even took adequate physical care of them. It was clear that the present separation to nursery school was evoking feelings within the mother of the earlier traumatic separation. After some time, I noted that I could see that she was very much afraid that she had really hurt Betsy emotionally, and this made it very hard for her to look at Betsy's problems. For example, at present there were understandable separation problems, and I described some of the observations and impressions of the school about Betsy's frozen

behavior. I noted that now things were different because while these were indeed problems, she was seeking help with them. The school could be helpful, talking here could help, and she herself could be enormously helpful to her daughter. We then began to see in our school observations that mother seemed less lost and more comforting to Betsy in the mornings when she was brought.

At the annual fall Halloween party at the school, Mrs. N. forgot to get a costume for Betsy. The following day she found an old Mighty Mouse costume that Betsy had used the previous year, and Betsy began carrying it will her all the time. She became inseparable from the costume and kept it with her at school, at home, out of doors, and at night. This obviously distressed Mrs. N. and she described that she knew she was finding ways of getting the costume away from Betsy. Mother was misplacing it often or washing it frequently. I began to discuss why Betsy held and clung to the costume. I noted how lonely and sad she felt at school, and how the costume was like having a little piece of mommie with her when she was away. Mrs. N. recalled Betsy's earlier attachments to a blanket and soft nylon fabrics. While the mother increasingly recognized the separation anxieties, she described them with fear. There was now much more clinging behavior at home. Betsy thumb sucked at times, and she always wanted to know what part of the house mother was in, particularly at night. I noted that Betsy was showing much more clearly how frightened she was about school and leaving her mother, and we now had the opportunity to help her put those feelings into words.

When mother pointed out Betsy's worries directly at home, talking broke out between the two. The mother reported that Betsy was really

terrified of school, and had all sorts of irrational fears. The teacher, Sandy, Betsy noted, was always angry with her, and she locks you in the closet if you are bad. She had many questions about what they did to Stephanie (an acting out pupil) when they took her out of the class. She alwa e day, missed her mommie very much, but she was afraid to cry. Sandy wouldn't like her if she didn't listen at school, like when she didn't hold onto the handle bars of the teeter-totter. Mrs. N. became aware that when these fears were expressed, they had less reality for Betsy, and she also found she could alert the school staff to some of Betsy's particular worries.

Once the talking started, it was hard to contain Betsy. She hated school because David stayed home with Mommie. From now on, when she came home she would sit in her mommie's lap all the time. When she was at school, she thought David and Mommie played cards all day and she just hated David because he stole all her things from her room when she was away. And it was clear after these discussions that Betsy felt much better and was less out of control.

Simultaneously, mother had memories of the impact of her hospitalization on the children. The Halloween incident helped her recall the Halloween weekend during her hospital stay. She had promised the children she would visit, but could not do so. She felt terrible about disappointing them, but she also recalled guiltily that she absolutely dreaded the visits with the children. She couldn't stand to face them when she had to leave. On her trial weekends subsequently, she always disappeared rather than say good-bye in the morning, because her children looked so terribly lost.

As Mother and Betsy's separation anxiety abated, Betsy "thawed" out at school and invested increasingly in the activities around her. She began to do more craft work at home. She colored with David, wanted her pictures hung up all over the house, and was having Leslie (sister) teach her letters and numbers. She began to constantly practice and write the letter "B" of her first name, and Mother was quite proud of her change.

With fall weather the mother became ill with upper respiratory infections which lasted, off and on, for several weeks. When she was not sick enough to go to bed, she often stayed on the couch and had Father increasingly take Betsy to school. Betsy was evidently upset. She reinstituted holding onto her costume, and her involvement in school learning tapered off. Then suddenly for a solid week when Betsy returned from school, she broke into a deep and intense sobbing that was hard for the mother to bear. Betsy also began a game with her mother; she would lie down on the couch and play that they were sick together.

The mother could quickly come to understand that Betsy's crying was an old crying that she had never expressed before, and her mother's present fatigue recalled the old sickness for her. Betsy, unlike the others, the mother told me, could not talk about the long hospitalization, and seemed to have no memories of it. But Mrs. N. was also frightened about entering into this area with Betsy. She felt she couldn't fully reassure Betsy because she didn't know if all of her own personal difficulty was over. In her next session with me she was very excited because she felt she had discovered an effective vehicle for slowly involving Betsy in this dreaded area. She talked freely with Leslie, who responded with many questions while Betsy silently listened to all the discussions. The older daughter asked mother why she had to go away, and the mother sensitively explained to the children for the

first time the nature of her problems. When she (the mother) was very young, her own mother and father travelled a lot for long periods of time, and left her with people who couldn't adequately take care of her. These experiences made for strong, sad feelings inside of her which she had never been able to understand and caused her a lot of trouble as a grown up. Now she was getting help with those feelings through talking with a special doctor. (One could not help but note the parallels and close identification between mother and daughter.) Betsy remained very attentive to these discussions.

Within the next few days, Betsy herself wanted to know all about the various doctors the mother saw. The baby doctor, the family doctor, and the talking doctor were distinguished. Betsy wanted to meet the talking doctor, and the mother made arrangements to have Betsy come to Hanna Pavilion (the place of hospitalization) and also meet the therapist briefly. Betsy recalled the old waiting room, the elevator, and her favorite nurse with whom she played ring-around-the-rosie when she visited her mom.

It was clear as we worked together that Mother's hospitalization had traumatic impact on Betsy which she could only slowly undo as mother herself reintegrated the old events.

PHASE II: PENIS ENVY AND THE PROBLEM OF SEXUAL IDENTIFICATION

After 6 months of treatment, the Mighty Mouse costume which had had transitional object importance to Betsy earlier, developed other meanings. The mother described that now the Mighty Mouse mask became prominent because in that way Betsy could pretend she was a boy. Mother brought some evident concern about Betsy's open sexual preference. Betsy was intensely disappointed with her Christmas presents. She

wanted the hockey sticks that David and Chris got, and she had a tantrum when they were hung in the boys' room. The word "weiner" was constantly used in the house, and it was Betsy's and David's word for David's penis. Upon inquiry, however, Betsy had no words for her own body except the word "toilet" which generally referred to Betsy's genitals. David and Betsy, at times, developed an exciting game when David asked to sit on her toilet.

Mother described Betsy's new habit of rubbing herself, particularly while watching TV. It made Mother very uneasy, and we discussed methods of having Betsy become more private with her masturbation. Bathroom policy had been to bathe David and Betsy together. However, since it was becoming evident that David delighted in showing himself off, Mrs. N. began to take appropriate educational steps within the home. Privacy around toileting and bathing grew, and Mrs. N. was able to distinguish sexual and exciting play between David and Betsy from fighting, and she could limit both better.

In early January, Betsy's sexual anxiety emerged more clearly. She was angry with all boys. Now Chris, the older brother, as well as David, were targets. She also began breaking her girl dolls. She cut off their clothing, drowned them, and cut their hair. Finally she made an attempt to cut her own long hair (cut out a big 'V' in front) and explained that she wanted her hair as short as David's. Mrs. N., after setting some controls with Betsy, began to point out to her that Betsy seemed to feel it was terrible to be a girl. For several days the triadic discussions arose with Leslie, Betsy and mother about sexual differences. Leslie was very curious, and she, Betsy, and mother named the parts of the body, discussed their functions, and noted how these

differences were there from birth. Though Betsy was relatively passive during these talks and interrupted by saying, "I'm scared, Mommie", there seemed to be evident relief and Mother was enormously pleased with her own efforts.

After a short, smooth period at home, the earlier messing patterns and increased body exhibiting occurred. Betsy was always picking up her own skirts. When Mother wondered with Betsy if she wasn't again showing some of her earlier boy-girl worries, Betsy began to argue that she indeed did have a "weiner". For several days she had many different theories. Nobody could see it yet, it was up inside. It could come out and go in, and when she was very young she had one. She insisted that little Jennifer (a newborn cousin) had one, and they would check together when she came to visit. Mrs. N. handled this material rather sensitively, pointing out that she had a big wish to be a boy, but that she was really a whole girl who had everything a girl should. Betsy reacted with some rather significant changes. For the first time she wanted to help her mother in the kitchen. She began to set the table and was in charge of tearing up lettuce for salad. She helped clear the dishes, and it was also her special job to serve desserts. Simultaneously, however, the ambivalence continued. Sudden outbreaks occurred against the boys, and Betsy, at times, took to sneaking on David's pajamas at night.

At the semester break in January, we decided to promote Betsy from half to a full day at nursery school. The change was very enhancing to Betsy. She had been waiting for a long time, she said, and this meant she was a bigger girl. Now she, like Leslie, goes to school for a full day. The mother reported that Betsy felt much closer to school. She

became a regular chatterbox at home, describing each activity of school fully and with pleasure. On the weekends she had to remember everything so she could tell Sandy (teacher) all about it when she returned.

Betsy continued throughout the year to show her ambivalence about her femininity. In early April, the class visited a regular kindergarten room, a preparatory gesture in anticipation of the next year. Betsy reacted with what appeared at first to be regressive behavior. She had taken some of Donald's rubber pants (youngest brother) to bed with her, and one night wore them. In discussing this with her mother, however, Betsy made a big point that she had taken a boy's rubber pants. She definitely didn't like the girl's kind with frills on them. In another discussion, Betsy brought out her concern about Stephanie (black child) at school. She didn't like her color, and she wished everyone was the same. She also, one day, told her mother that Batman was now her favorite TV program, and she could do everything that Batman could do (like jump down 4 steps) and she wished there was such a thing as Lady Batman. The male wishes continued, and needed continued working through.

Betsy was also showing some increased teasing of mother. Earlier it had been a game where mother would find her, and it involved separation themes. Now there seemed to be much more anger directly expressed. With much empathy and using all of the recent incidents, Mrs. N. had a number of discussions with Betsy about her continued wish to be a boy. Everyone should be the same - black and white, boys and girls. Maybe, the mother wondered, Betsy was very angry with her at times, because as her mommie she didn't make her a little boy like Donald when she was born. As they talked there was an increase in Betsy's aggression toward David through open biting, along with her verbalization that she hated all

boys. Mrs. N. discussed the meaning of the biting. Since Betsy often showed acute remorse about hurting David after an attack, she spoke to Betsy in the context of helping her to stop. There was an angry part inside of Betsy that wanted to bite David. This was the part that was angry with boys because they had weiners, and like many girls, Betsy sometimes wanted to bite off the weiner. But this really wouldn't help her become a boy. This seemed to be an important interpretation to Betsy because much of the aggression abated after this period.

A new seductiveness emerged instead that was directed toward Chris, the older adolescent brother. She was often touching him or playfully inviting him to wrestle. She was very interested in Chris' bed, loved to watch TV on it and bounce up and down on it. As she seemed to be more comfortable with becoming a girl and woman, Betsy expressed strong feminine excitements.

As nursery school advanced and preparations for kindergarten were discussed, Betsy began to talk directly with her mother about her worries about school. Who would go with her to her class, where would school be held, etc.? And she also immediately talked about her worry about having a baby. She decided she didn't want to have a baby. She didn't want to go to a hospital since the doctors hurt you there. She didn't think babies could really come out of a baby hole. Look how big Donald was, and how little her hole was. The mother could again discuss the process of child birth, and also reassure Betsy that growing up and going to kindergarten didn't mean that she would be a woman and have a baby right away.

TERMINATION: THE MUTUAL IDENTIFICATION OF MOTHER AND DAUGHTER

Throughout the treatment, I was aware of a strong overidentification between Betsy and Mother. It seemed clear that Mrs. N. seemed to relive some of her own terrors of childhood by re-experiencing them through Betsy. And Betsy, on her part, kept her mother closer to her when she herself became like Mother (ill, depressed and frozen). Through the treatment process, as Betsy found gratification through learning and activity, we increasingly saw less of the depressed mother in Betsy. In the latter part of our work, there were increasing opportunities to help Mother specifically become aware of her need to overidentify with her daughter, and narcissistically endow her with her own feelings.

On one occasion, Mother reported that Betsy awoke several times one night with an anxiety dream about a fat man sitting on her. Mother was very upset, and she had a rather strange reaction. She noted that when she was a child, she herself had been attacked by a fat man. How could Betsy know that? It was an opportunity to help Mother separate her reactions from her daughter, and I was therefore quite puzzled with Mrs. N. and wondered why she would connect Betsy's dream with her own experience. I underlined the naturalness and commonness of this kind of fantasy in a little girl (recent excitement and aggression with her daddy seemed like natural sources for the dream content). Perhaps there were times, I noted, that Mrs. N. somehow put feelings onto Betsy that came solely from her own past. There were a number of occasions I could gently point out this puzzling process, which Mrs. N. could increasingly come to understand. She spoke directly about her concerns about Betsy. She indeed always had a fear that Betsy would turn out exactly like her,

and she wondered if that wasn't really her underlying reason for the referral to us. The more she heard Betsy talk directly about herself and bring her own thoughts, the more reassured she felt.

In the spring, as we neared the end of the nursery school year, Mrs. N. was "not with it". She seemed pale, preoccupied, and brought few observations about her daughter. It was like a repetition of the earliest period of our work. When I noted her lack of involvement recently, she commented that she was not feeling well physically because of "female trouble". It later emerged that she was trying a new contraceptive device (a loop), and reacted by excessive bleeding. I was aware, however, that Mrs. N. attempted to cope with earlier depressions by becoming pregnant, and that her physical complaints often heralded emotional crises.

For several weeks it was clear she was becoming acutely despondent. She could cope less with Betsy's teasing of her or exciting play between Betsy and David. She appeared helpless under the force of her internal difficulties, and with me was apologetic and distraught about the neglect of her children. We spoke together about her temporary need for additional help at home, and she had a family maid live in for a period of time. We also met conjointly with Father during this period. Mrs. N.'s therapist was on vacation, and she acted out her distress. She took excessive tranquilizers so that she was often groggy. She wandered away from home for several hours one evening without informing anyone of her whereabouts. On another occasion, she shattered a window by throwing a cup through it. Mrs. N. kept her sessions with me, indicating that she was determined to try to stay out of the hospital. She noted repeatedly that she was beset with horrible childhood memories and anxieties. However,

I must add, she used her time with me appropriately. She made no attempt to share these memories with me, and it was as if we were both waiting for her therapist to return. She could describe what was happening to Betsy at home, but she made it clear she would not talk with the children now. I felt my presence was a stabilizing factor during this turmoil, and that it served as a temporary and indirect link to her own therapist. The crisis passed shortly after the return of Mrs. N.'s psychiatrist.

Though this was a very difficult period for the entire family, there was little regression in Betsy. The waif-like, lost, wandering child did not reappear at the nursery school. During this period she appropriately intensified relationships with teachers and peers. She formed a strong and exclusive attachment to a girl friend which barred outsiders, and she sought to have this peer, Judy, all to herself. This was clearly an active step to cope with loss through constructive means, in contrast to the aimlessness and overwhelmed inhibition we noted earlier.

The mother quickly became active as she felt better, and reinvolved in her work. For example, when Betsy came in to check on Mother's whereabouts, they could talk together about the fears that Mother would go away again stimulated by the recent events. Betsy began to use the word "upsetness" referring to mother's mood and depression. Mother could acknowledge that there might be times she would get her "upsetness" again. Betsy actively wanted to know why the "upsetness" came again, and they reworked some of the childhood events they had earlier discussed. As Betsy used the word "upsetness" it more clearly became a distinct phenomena linked solely with Mother.

As we neared termination, we were pleased with Betsy's progress. She showed much less ambivalent behavior toward her parents and much more control with her brothers. She functioned adequately in all the pre-primer readiness tests that was part of the nursery school curriculum. We saw little of her inhibitions. Her ability to play with peers appropriately and enter new situations markedly improved. She was involved and accepted by children of her age, and able to sustain continuous and structured games.

DISCUSSION

At the start of treatment, we were enormously concerned about Betsy's personality functioning. We noted the severe separation problems and sense of disorientation. Her primitive aggressive expression had early anal and oral forms (biting, hitting, messing). Our greatest concern, however, seemed to be the generalized ego arrest. Speech was not used for effective communication. Betsy's synthetic functioning was poor, and she was unable to orient herself in new surroundings. She not only showed a marked lack of general skills, but also she could not invest and involve herself in activities around her. She generally tended to restrict herself, seemed phobic of the world, and used regression prominently in the face of stress. Our observations indicated that her defenses were also not adequate to most situations, and her states of anxiety seemed to paralyze her ego.

Therefore, we were worried we were dealing with problems of early ego arrest, and that we were watching the unfolding of the development of an atypical or borderline personality structure. History could confirm this hypothesis, since we could speculate an early libidinal

decathexis of Betsy by her mother with the onset of the mother's depression. There seemed to be evidence that Betsy had little primary self-investment and self-regard, and a poor ability to neutralize instinctual energy.

However, as we began to work with Mother and Betsy, strides were quickly made within the first few months. After Mother began to discuss her extreme guilt over the impact of her depression on Betsy, we became aware that we were dealing with a different kind of problem. Betsy's general lack of progress was centered on a strong identification with her depressed mother, and this process was reinforced markedly by the mother. Mother was terrified that this child represented the depressed part of herself, and she reacted with guilt to Betsy by giving in to her demands and primitive needs. Betsy used this identification process for two purposes: to keep her mother close to herself by becoming like her, and also to ward off the fears of the environment around her by inwardly living a constant mother-child union in fantasy. Much of Betsy's pathology, therefore, was based on secondary interference of ego functions, as a result of this pathological identification.

Within the process of treatment with the mother, as I specifically identified the feelings that Betsy had (e.g., toward nursery school or her brother), mother experienced much relief. It was as though I was constantly pointing out that Betsy had a whole raft of her own feelings and thoughts, and she was reassured that Betsy was not a carbon copy of herself. This allowed Mother to increasingly differentiate Betsy, and we saw a growing shift from narcissistic investment to more wholesome object relatedness. Mother developed a searching attitude about

Betsy, made realistic observations and reports, and had independent insights about her functioning. She improved in her ability to empathize and communicate with her.

Mother was then much more able to become an adequate emotional educator for Betsy, as she had been with the other children. She actively interfered with the primitive aggressive outbursts, and slowly helped her daughter express her anger through verbalization. This process went on, not only in relation to Betsy's relationship with her brothers, but also directly with her child's aggression toward the mother herself. There is little question that this handling enormously helped her daughter, who was terrified of the flooding of her aggressive impulses. She also became able to help Betsy reconstruct the difficult realities of the past - her own traumatic hospitalization and the meaning of the mother's illness. In addition, for the first time she could express open pleasure and pride in the tentative and growing cognitive achievements that Betsy was able to accomplish, and this stimulated further sublimatory activity.

With the growing rapport between Mother and daughter, Betsy quickly moved into phallic and oedipal problems which were phase-adequate for her age. Her masturbatory and excitement problems unfolded, and Mother was able to skillfully help her work through some of her concerns of penis envy and her fears of femininity.

At the close of treatment, though there were many evident gains, we were left with some doubts. Betsy retained some tendency to turn aggression against herself, and this showed in some of her motoric awkwardness and tendency to minor injuries. Despite her attempts to

make herself pretty and draw positive attention to herself, there was still an inner lack of self-assurance about her. Of greatest concern, however, was Mother's ability to continue to see Betsy in terms of adequate positive object cathexis, rather than including her child in her concept of what was "wrong" with herself (the mother). We wondered. Did Mother's effective work depend on her relationships with her therapist (me) and the nursery school teachers? From subsequent reports Betsy was able to go through her kindergarten year quite well, and we saw little regression during that following year.

As I noted in the introduction, the process of "treatment via the mother" particularly capitalizes on the close unconscious communication between Mother and the young child. In this case this form of treatment seemed particularly appropriate since much of the central cause of the problem rested on the unconscious bond and identifications between Mother and daughter. Once the mother became somewhat free to observe her daughter, her intimate symbolic understanding of Betsy was particularly useful in the treatment process. Mrs. N. often understood the developing conflicts before I could infer them, and I often functioned as someone who affirmed and corroborated her intuitive impressions. A major additional advantage of this process was also the timing of interventions. Mrs. N. was able to often discuss and interpret material with her daughter as situations developed in the "life-space" of their lives. Her interventions could be particularly effective because they came quickly after affective encounters (fighting with her brothers, separations, etc.).

It was interesting to note that, despite the evident psychopathology of the mother, there was enough healthy ego that could be enlisted in the process of helping her daughter. Mrs. N. was often severely depressed, had a history of hospitalizations, and yet managed to mobilize energy to sensitively help her child through developmental crises. The process of "treatment via the mother" can often capitalize on the healthy, adaptive energy devoted to parenting, despite conflicts in other areas of the parent's life.

I also feel that this particular form of treatment helps to develop transference boundaries between therapist and Mother that permits maximizing work. Though Mrs. N. was evidently tempted at times to becomes my primary patient or take me on an auxiliary therapist, the reality task we had defined together (and repeatedly reaffirmed) served to limit transference regressions. In the process of our work together, I made relatively few comments about her relationship to me, except as it dealt with her role as a mother. While this limitation caused temporary frustrations for Mrs. N., I felt that it served to constantly clarify the limits of our mutual task, and facilitated help for Betsy during the critical developmental years.

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